BHSF Wages
Rev. 01/01
Prior Issues Usable
IV

MEDICAID PROGRAM
PERSONAL WAGE RECORD

Work Record for: _____ SSN _____ Case ID # _____

Please keep a record of your employment as indicated below. Return this form to the Medicaid Program representative by _____.

Dates Worked	Employer	Employer Address	Employer Phone	# of Hours Worked	Gross Amount Earned	Date Wages Received

_____ _____

Signature of Applicant/Recipient Date